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McDermott, A.M. and Pedersen, A. R. (2016) Conceptions of patients and their roles in healthcare: Insights from everyday practice and service improvement. *Journal of Health Organization and Management*. Volume 30, Issue 2.

**Conceptions of patients and their roles in healthcare:
Insights from everyday practice and service improvement**

Purpose: The purpose of this paper is two-fold. First, it sets the context for the special issue by considering conceptions of patients and their roles in service delivery and improvement. Second, it introduces the contributions to the special issue, and identifies thematic resonance.

Design/Methodology/Approach: The paper utilises a literature synthesis and thematic analysis of the special issue submissions. These emanated from the 9th International Organisational Behaviour in Healthcare Conference, hosted by Copenhagen Business School on behalf of the Learned Society for Studies in Organizing Healthcare (SHOC).

Findings: The articles evidence a range of perspectives on patients' roles in healthcare. These range from their being subject to, a mobilising focus for, and active participants in service delivery and improvement. Building upon the potential patient roles identified, this editorial develops five 'ideal type' patient positions in healthcare delivery and improvement. These recognise that patients' engagement with health care services is influenced both by personal characteristics and circumstances, which affect patients' *openness* to engaging with health services, as well as the *opportunities* afforded to patients to engage, by organizations and their employees.

Originality/Value: The paper explores the relationally embedded nature of patient involvement in healthcare, inherent in the interdependence between patient and providers' roles. The typology aims to prompt discussion regarding the conceptualisation patients' roles in healthcare organisations, and the individual, employee, organisational and contextual factors that may help and hinder their involvement in service delivery and improvement. We close by noting four areas meriting further research attention, and potentially useful theoretical lenses.

Conceptions of patients and their roles in healthcare: Insights from everyday practice and service improvement

Conceptions of patients and their roles within healthcare range from traditional passive perceptions of service recipients, to more recent contributions positioning patient involvement as integral to service delivery, planning and improvement processes (Armstrong et al., 2013; Bate and Roberts, 2006; Hardyman et al., 2015). This shift in emphasis has occurred for a variety of reasons – including recognition of patients as service stakeholders (users and funders), underpinned by principles of participative democracy (Milewa, 2004); the rise of patient centred care, premised on ‘*recognition that patients’ values and preferences should take centre stage in the delivery of care, at both the organisational and the professional level*’ (Keating et al. 2013, 2); as well as appreciation of potential for patients to help improve the quality (Armstrong et al., 2013), safety (Sutton et al., 2015) and efficiency (Bate and Robert, 2007) of services. The terms patient involvement and patient participation are often used interchangeably (see, for example, Härter et al., 2011). In practice, they can take a variety of forms and concern patients’ involvement in decision-making about their own care (often discussed in the context of shared-decision making, focused on clarifying acceptable and preferred care options and outcomes – see Edwards and Elwyn, 2006; Sheridan et al., 2004), as well as involvement in planning and developing services (see Crawford et al., 2002). Scope for user involvement has also been identified at the macro policy level (Härter et al., 2011). However, this is not considered here, where we adopt a more micro (patient-provider interactions) and meso (team and organisation level) focus. Specifically, this special issue considers conceptions of patients and their roles in service delivery and improvement in five articles, showcasing research from the US, Europe and UK. The articles were submitted to the 9th International Organisational Behaviour in Healthcare Conference, hosted by Copenhagen Business School on behalf of the Learned Society for Studies in Organizing Healthcare (SHOC). Reflecting the interdisciplinary nature of the SHOC community, the articles are premised on a wide range of methods including document analysis, surveys, interviews and ethnography (utilising multiple data sources, including observation, interviews, questionnaires, reflective diaries and service improvement logs). The conference invited researchers to consider the challenges and dilemmas evident in the everyday practice of healthcare. Healthcare has an inherent focus on providing and improving services for patients, so it is perhaps unsurprising that the selected articles evidence a range of roles assigned and adopted by patients (and their information) during ongoing service delivery and improvement, as well as the factors influencing these. Building on the collective contributions of the articles, we develop five ‘ideal types’ of patient positions in healthcare delivery and improvement. These are premised on recognition that patients’ engagement with health care services is influenced by the relational interface between their *openness* to engaging, and the *opportunities* afforded to them to do so, by organizations and their employees. We then consider the particular potential contributions of patients to improvement and innovation processes, before detailing the specific contributions made by each article. We conclude by identifying an agenda for future research.

Patients’ roles in healthcare: Openness and opportunities to engage

Common across the five articles in the special issue is recognition of the centrality of patients to healthcare practice. This manifests in multiple ways, including ensuring the privacy of patients and their information (Anthony and Stablein, US); working to establish patient centred

teamwork, by building shared mental models (Körner et al., Germany); informing and empowering patients via communication programmes (Pors, Denmark); using patient perspectives (in the form of focus group interviews, diaries and audio recordings) to create meaning and motivate professional engagement in innovation projects (Pedersen, Denmark); and direct patient engagement in experience-based co-design of services (Boaz et al., UK). Thus the articles evidence perspectives on the role of service users that range from their being subject to organisational systems, processes and work practices (Anthony and Stablein, 2016), to serving as a mobilising focus for interprofessional practice (Körner et al., 2016), to informing (Pedersen, 2016) and acting as active participants in improvement (Boaz et al., 2016). Finally, our closing article drawing attention to six conceptions of patients along a passive-active spectrum - sometimes simultaneously evident - in a hospital communication programme (Pors, 2016). Collectively, the articles illuminate both differences in patients' openness and motivation to proactively engage with services and their improvement (Boaz et al., 2016; Pors, 2016), and variation in the nature and scope of the opportunities afforded to them to do so. Importantly, patients' openness to being an active participant in, or influencer of services, is affected by their personal characteristics and circumstances (e.g. health, ability, interest, time, health literacy etc. – see later). In contrast, the opportunities afforded to patients to become active agents are influenced by organisations and their employees. Both openness and opportunities are required for proactive patient involvement to occur – meaning that patient involvement in health care is a function of interactions between patients and providers. We now turn to consider the factors influencing patient openness to, and organisational opportunities for, engaging patients as partners in service delivery and improvement.

Numerous authors have identified potential to reconfigure the role of the patient from a passive recipient to an active collaborator in service delivery (such as in making shared decisions about their own care – see Renz et al., 2013) and service improvement (Bate and Robert, 2006). However, discussion about the factors influencing the extent to which patients are open and motivated to engage with service delivery and improvement has been much more limited. One review found that age, education status and disease severity influence the desire for participation, with ethnic or cultural factors also potentially influencing (Coulter and Ellins, 2006). Additional factors may include health literacy (Smith et al., 2009), knowledge, experience, personality and trust within the patient-provider relationship (Thompson, 2007). The potential range of influencing factors, together with personal differences, make it important to elicit information regarding individuals' preferences, rather than making assumptions (Coulter and Ellins, 2006) – and to check whether preferences have shifted over time (Thompson, 2007).

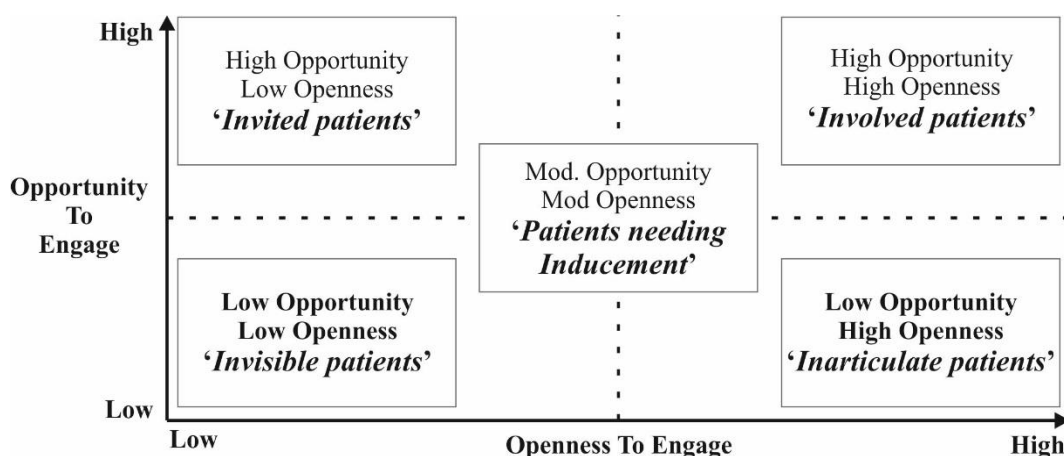
Some patients may feel unable to proactively contribute – due to lack of guidance on service quality (Berry and Bendapudi, 2007), or for time or health reasons. For example, Boaz et al. (2016) in this volume note that some patients who initially participated in service improvement processes became progressively ill, and could no longer attend. However, authors of another study question whether professional conceptions of patients with schizophrenia as 'too ill' to participate in shared decision-making reflect providers' prejudice, or a true lack of capacity among patients (Hamann et al., 2006). This raises the importance of considering both patient openness to, and provider opportunities for, patient engagement:

'doctors rated many patients as being incapable of making reasonable decisions. It can only be speculated whether these numbers reflect incapacity on the part of the patients or the prejudices of doctors/ nurses. In our trial, incapable patients exhibited very few key characteristics: interestingly enough, it is not the group of very psychotic or aggressive patients who are incapable, but rather those with predominantly negative

symptoms or those declaring no interest in participation. Thus the problem might not be that these patients choose irrational treatment options, but rather that they are not interested in thinking about and deciding on these issues. This fact is however no obstacle to SDM [shared decision-making], since SDM does not aim at forcing patients to be active decision makers but rather wishes to offer them a choice, which they need not to accept. For those patients the paternalistic doctor is probably still acceptable. (Hamann et al., 2006, 271-272)

The quote above emphasises that some patients may lack an interest or willingness to engage with service delivery/improvement - an exercise of their personal agency that requires further research (Berry and Bendapudi, 2007) as well as pragmatic attention. Indeed, in this special issue, Pors (2016) found little evidence of strategies to support those exercising their right to deliberately disengage, by electing to opt out of receiving information and not availing of shared decision making. Other patients may adopt passive, reactive or proactive roles in service delivery and improvement (Pors, 2016). Patients' roles may reflect their personal circumstances and physical and psychological wellbeing (Boaz et al., 2016); their openness and motivation to engage with service delivery and improvement (influenced by the factors previously detailed); and the opportunities afforded to them to contribute. In the context of service improvement, some suggest that despite developments in the literature, opportunities for patients to contribute remain limited (Storm and Edwards, 2013). These predominantly involve the collection of data about patient experience and satisfaction (through surveys, focus groups, storytelling, online feedback etc.), with more limited scope to act as partners in service design and improvement (Robert et al., 2015). Variation in levels of opportunity to participate are evident across the articles in this special issue – reflecting Bate and Roberts' (2006) differentiation between designing systems and improvements *around* versus *with* patients. Indeed, some areas still appear to be perceived as beyond the sphere of patient influence – with Anthony and Stablein (2016) noting professionals responding in multiple ways, on behalf of predominantly passive patient subjects of ICT systems, processes and practices. Reflecting differences in the opportunities afforded to patients to engage with services, as well as their openness and willingness to do so, we develop a preliminary typology of patient roles that can be applied to service delivery and/or improvement. This draws attention to potential patient and organisational/professional influences on patient participation and involvement.

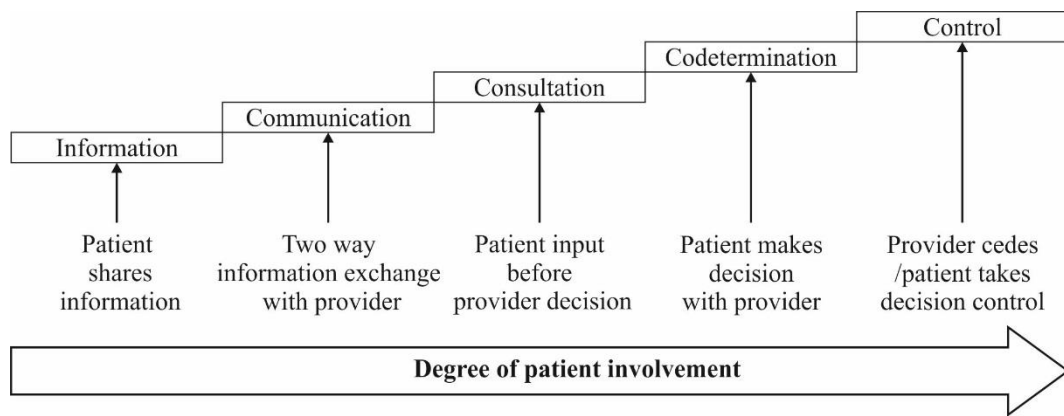
Figure 1: Ideal types of patient positions in healthcare delivery and improvement (Guest editors' own)



In Figure 1, five ‘ideal types’ of patient positions within organizations are identified. First we note those theoretically celebrated as ‘*Involved*’ individuals (Q1, high opportunity, high openness), who are personally open to engaging, and afforded opportunities to do so by organisations. Second, we also note potential for individuals to be ‘*Invited*’ to participate (Q2, high opportunity, low openness), by being afforded opportunities to engage with service delivery and/or improvement that they may neither wish to, nor be in a position to avail of. Third, we note that the potential contributions of patients may be ‘*Invisible*’ (Q3, low opportunity, low openness), with neither individuals nor organizations promoting patients as active agents in healthcare delivery and/or improvement. Fourth, we note potential for patients to be made ‘*Inarticulate*’ (Q4, low opportunity, high openness), with openness to engaging - and potentially significant contributions - but no opportunities afforded by the organization to make them. Last we note a category of patients who may need to be ‘*Induced*’ to be involved – holding a middle ground, with a degree of openness that may require persuasion to become explicitly enacted, combined with an organizational context providing some opportunities for engagement. This typology builds upon previous overviews of patient engagement (e.g. see Thompson (2007)), to incorporate explicit focus on the opportunities to participate afforded by organisations and the professionals within them. Thus, in presenting these positions, we emphasise that they are a product of relational engagement between patients and providers. In addition, we note that the roles are not static. Rather, there is potential for patients’ to transition between roles, due both to changes in their personal capacity to engage (e.g. severity of illness; time available) and their interest in engaging. We also note potential for patients to transition between roles due to changes in the opportunities afforded to them to engage with services (e.g. differences between personal styles of care providers and/or formal organisational opportunities for input, such as surveys/focus groups/experience based co-design). The typology therefore draws attention to implications for organisations’ systems and professionals’ roles in affording opportunities for patients to participate in service delivery and improvement, and supporting them to avail of these. Thus, achieving patient involvement (or invitation) creates extended roles and responsibilities for healthcare professionals and organisations, as well as patients.

While Figure 1 attempts to capture the intersection between patient and provider factors influencing patient roles, we note that forms of patient participation may mirror those evident in studies of employee contributions to organizations. Of particular note is the escalator of participation (Marchington and Wilkinson, 2005), which illustrates different levels of employee’ influence on decisions. We modify this below, to reflect a patient orientation.

Figure 2: Patient involvement in decision making and service improvement (Adapted escalator of participation, Marchington and Wilkinson, 2005)



This typology draws attention to the potential for patients to be informed about the decisions made for and about their care or service; to be consulted and have input prior to decision-making; to jointly codetermine the outcome, or to take control. Importantly, Marchington and Wilkinson (2005) note that the model is scalable across individuals, tasks and organisations – making it applicable to relatively small scale individual choices (e.g. what will I have for lunch?), to care related decisions (e.g. what treatment should I have; which treatment centre will I choose?), as well as to departmental and organisational issues (e.g. how can this service be improved?). While this model does mirror existing patient-oriented typologies (see, for example, the patient power continuum in Thompson, 2007 – with exclusion, paternalism, shared decision-making and informed decision-making), it also draws attention to potential for theoretical cross-fertilisation between studies of patient and employee’ involvement. Next, we specifically consider the potential roles of patients’ in improvement and innovation processes.

The role of patients in scoping and implementing improvement and innovation

In addition to the centrality of patients’ to service delivery, the papers draw particular attention to patients’ roles in responding to, prompting and participating in change processes. Healthcare change can be prompted by a variety of sources – including policy reforms; technological or employer driven innovation; professionally collated evidence or research; or as we see in this special issue, patient experience in a variety of forms (surveys, complaints, narratives and face-to-face input). While significant attention has been afforded to responses to large scale policy initiatives (McDermott et al., 2013), the papers in this special issue draw attention to the often incremental nature of change, which occurs within the local context of healthcare organizations (Weick and Quinn, 1999). Boaz et al. (2016) consider the impact of quality improvement projects in acute hospitals; Körner et al. (2016) describe team collaboration in a medical rehabilitation clinic; Pedersen (2016) details how employee driven innovation projects in breast cancer and cardiology clinics are resulting in small changes; Anthony and Stablein (2016) note micro amendments to professional practice, in response to changes in understanding of privacy prompted by IT developments. Regardless of the content of change, organizations must consider how to integrate new initiatives into the day-to-day practice of service delivery. Implementation involves translating new ideas (Callon 1986) into everyday practices, by, for example, creating salient perceptions, facilitating sense making and/or sharing and enacting knowledge. The papers in this special issue draw attention to how patient input can assist in translating changes, by serving as a mobilising focus (Pors, 2016) problematizing the status quo, supporting changes in attitude and the emergence of new meanings (Boaz et al., 2016; Pedersen, 2016). They also draw attention to associated changes in professional practice

(Anthony and Stablein, 2016). However, reflecting prior research, the papers evidence the complexity of translation processes, and the benefits of platforms for collaborations between health care professionals and patients, as well as the work inherent in delivering them (Scott et al. 2003). Patient-provider interactions can occur with individual professionals; with interprofessional teams (Körner et al., 2016); and in forms one-step removed, via sharing of IT embedded information (Anthony and Stablein, 2016). While the traditional platform for collaboration between patients and health care professionals has been via personal consultation, the articles in this special issue demonstrate how an increasing range of platforms for information sharing, including films, workshops, IT platforms and communication documents are creating new forms of, and spaces for, collaboration (Pedersen 2009) – and an increasing range of roles for patients (Pors, 2016). In summary, the contributions to this special issue demonstrate the centrality of patients to healthcare practice, the implications of the increasingly recognised and enacted potential for patient proactivity in service delivery and improvement – and the relational reshaping of professional and patient positions and roles within healthcare. Of course, these developments are ongoing and emergent – and there is significant scope for research to add to our understanding. Next we consider the specific contributions of the articles included in this volume. We conclude by identifying four areas requiring particular research attention.

Overview of papers

Anthony and Stablein (2016) consider ‘Privacy in practice’, exploring clinical and non-clinical professionals’ (doctors, nurses and health information staff) discourse about the control of patients’ information in healthcare, by undertaking eighty-three in-depth interviews. This is a central, and insufficiently discussed concern in health care delivery, due to developments in information technology, and the foundational role of disclosure within the patient-provider relationship. Interviews considered the nature of ‘privacy’; perceived reasons for protecting patients’ privacy; who is responsible for doing this; the actions taken to achieve this; and the impact of developments in IT on clinical professionals’ control of patient information. Many authors have suggested that the focus on communication in healthcare has shifted beyond considerations of face-to-face interactions between clinicians and patients in clinical settings (Epstein et al., 2005), and now includes organisationally coordinated and controlled strategies and practices (see Pors, 2016 in this volume). Anthony and Stablein (2016) evidence a similar shift with regards to patient information – that is now embedded and shared via technology, rather than held within the confines of patient-provider interactions. This means that IT staff now play an important role in managing patients’ information. Across the respondents, patient confidentiality and information protection are perceived as important values, but interpreted in diverse ways. Anthony and Stablein (2016) suggest that while physicians see privacy as embedded in trusting relationships and the practice of confidentiality, nurses emphasise appropriate access to, and protecting the privacy of, information in their occupational work and interactions with patients. However IT professionals have a more organizational focus – affording attention to privacy of patient records and IT systems. Importantly Anthony and Stablein (2016) note that changes in the number (and nature) of individuals with access to patient information is changing the content – as clinical professionals protect patients’ privacy by vague recording. This raises questions about whether such systems are inimical to their purpose: impeding flows of information and reducing the quality of communication between care providers about (and possibly with) patients. How can patients be encouraged to share

information, if they lack confidence in its security – or certainty regarding its implications? Could the information sharing enabled by IT systems undermine patient participation in healthcare? Anthony and Stablein's (2016) paper draws attention to a need for discussion between organisations, professionals and patients, regarding what 'privacy' means in a world with increasing use of electronic health records, longstanding digital footprints, and individual professionals' decreasing control over patient information, once entered in systems – all of which affect the basis on which patients share information. The changing nature of information control and associated implications for professional practice, information sharing and patient confidentiality require significant further research attention.

Turning from collating to integrating knowledge, Körner et al. (2016) use cross-sectional survey data from rehabilitation centres in Germany to identify patient-centred teamwork as a partial mediator between perceived knowledge integration (the process of building shared mental models) and team performance in interprofessional contexts. Patient centred teamwork is focused on representatives of different healthcare professions working towards a shared goal, to provide the best service and outcomes to patients. The paper fundamentally addresses the challenges and possibilities of collaboration in healthcare (West and Lyobovnikova, 2013). Effective teamwork has been associated with a range of positive performance outcomes in healthcare (Ezziane et al., 2012) – with poorer outcomes evident where constructive collaboration is lacking. Körner et al.'s (2016) findings suggest that knowledge integration is positively associated with team performance. However, physicians are found to have a more positive perception of knowledge integration than other groups, potentially related to differences in expectations, values and power between health care professions. Furthermore the findings show the positive effects of knowledge integration on patient centered teamwork and team performance. Overall, the study confirms the importance of the integration of different perspectives across health professions – and discussion suggests the importance of interprofessional training and team interventions, to bridge differences in perspectives. We note potential for patient input to such training.

Pedersen (2016) shifts attention from day-to-day service delivery, to service improvement. Using interview based case studies, she considers the role of patient narratives in mobilising improvement and innovation processes, recognised as particularly challenging in healthcare (Ferlie et al., 2005). Patient narratives are explicated as a strategy for problematizing existing processes and routines. Compiled in written form on the basis of diary entries, and in audio form based on extracts of interviews, the narratives are shown to help to give professionals' greater understanding of patients' experiences, illuminate differences in perspective, and enrol and mobilise professionals in support of improvement efforts. Pedersen (2016) argues that her findings help explicate the role of communication, and the development of meanings, in the translation of improvements and innovations. For her, making change meaningful is a key enabler, encouraging and enhancing professionals' participation in change. Importantly, the patient narratives evident in the study involved the active engagement of patients, but were presented in a disembodied form, one step removed from the patients themselves. Regardless, they assisted the translation of improvement by creating space for reflection and supporting the emergence of new perceptions and meanings, via personal and emotional reactions and reflections. In summary, Pedersen (2016) evidences the potential of patient narratives as problematizing, meaning creation and mobilising devices – helping to make change meaningful for busy professionals, and illustrating the benefits of integrating patient perspectives into change programmes. Indeed, this theme acts as a bridge between our third and fourth papers.

Reflecting the longstanding and increasing attention being afforded to involving patients in implementation and improvement processes (Crawford et al., 2002), Boaz et al. (2016) start

from the premise that patient experience research is a valuable source of knowledge and evidence to inform quality improvement (Robert and Cornwell 2011; Robert et al 2015). Using an ethnographic approach, they explore the different active engagement roles undertaken by patients, carers and the public, within participatory quality improvement processes; the resulting activities; and their impact on healthcare services. The processes studied by Boaz et al. (2016) were differentiated from the patient narratives explored by Pedersen (2016) by the opportunity for patients and carers to work directly together with staff. However both studies suggest that patient input influences staff attitudes. In addition, Boaz et al. (2016) found that, while challenging for staff, the direct involvement of patients and carers helped to dispel preconceptions, improve staff motivation for change, increase mutual accountability and promote the value placed on patient input. Patients' contributions included sharing experiences, identifying improvement priorities and developing potential solutions: they also noted that patients tended to see implementation as more of an organisational than a patient-related responsibility. Importantly, Boaz et al. (2016) identify the relatively 'small-scale' nature of many of the identified changes, and argue that organizational change does not have to be radical to be beneficial: locally initiated, small scale collaborations between patients and staff can succeed in improving patient experiences. Thus, a key contribution of Boaz et al.'s study is a challenge to the assumption that minor change is inconsequential – with respondents suggesting that the changes were small in scale, but large in impact. The authors argue that such changes are not alone valued by patients, but may also have benefits for organizational receptivity to change, as well as the broader organizational culture.

Last, using document analysis Pors (2016) considers constructions of the patient in a Danish hospital's patient-centred communication programme. Patient-centredness is increasingly manifest not alone in patient-provider interactions, but in the broader context of organisational service design and delivery. Health care management is an increasingly communicatively conditioned field, with a rise in hospital branding, and an emergence of new communication tools, including leaflets, internet pages, and flyers to engage with patients. Based on her analysis of a communication programme, Pors (2016) identifies six conceptions of the patient, differentiated according to whether they are perceived as an active partner, reacting co-actor or a passive recipient of care – and whether this is filtered through an ethical, care oriented lens, or a more market oriented perspective. Pors (2016) argues that, as passive recipients, patients can either be conceptualised as affective yet passive individual recipients of care, or as homogenized target group for interventions. As reacting co-actors, patients can be perceived as citizens with rights, or as a competent resource to support their own care. Last, perceptions of patients as active partners can either present them as service users who are responsible participants in their own care, or as consumers - active customers planning their own care. Importantly, Pors (2016) notes potential for management '*of*' and '*through*' patients – who are a key focus in developing healthcare delivery. For her, strategic communication becomes a means of organising and coordinating patient-professional relations. At times this manifests via direct attempts to influence patient behaviour, while indirect attempts to mobilise hospital employees using a patient focus are also evident. Importantly, the findings suggest that patient centred communication efforts reflect, rather than resolve, differences between care and market imperatives. For Pors (2016), the patient emerges as a political figure, with multiple conceptions potentially evident in simultaneous use, to support the management and transformation of health services. In other words, she evidences how communication is used as an organizing force in the health care sector (Kjær, Pedersen and Pors 2016, forthcoming). To conclude, we develop implications for future research.

Future research

Based on the contributions to this special issue and the themes raised in this editorial, we emphasise a need to consider the relationally embedded nature of patient involvement in healthcare. This is premised on interaction between patients and providers, and influenced both by patient openness to engaging with health care services, and the opportunities afforded to them (by organisations and their employees) to do so. Thus our typology explicitly draws attention to the interdependence between patient and providers' roles. On this basis, there is a need to consider the implications of enhancing patients' involvement in healthcare for the organisation of services, the work of health care professionals, and the patients themselves. In particular, we note a need to consider (1) 'How can organizations foster patients' openness and readiness to move from passive to more active roles in service delivery and improvement?' In particular, there is scope for future research to consider the factors supporting and hindering patients' openness and motivation to engage in service delivery and improvement. In support of this, there is potential to draw on literature from services marketing, including the seminal model of consumer co-creation of value (Lusch, Vargo and O'Brien, 2007). Indeed, as noted by Berry and Bendapudi (2007), there is particular potential for collaboration between health service and service researchers more broadly (see Hardyman et al. (2015) for a recent example).

Second, we note scope for future research to identify (2) 'What strategies, processes, events and participation mechanisms can organizations adopt to provide opportunities for patients' active involvement in service delivery and improvement?' Here we note potential for research on employee participation (see Marchington and Wilkinson, 2005) to provide insight into types of patient input, when it might be appropriate, and how it might be elicited. This is particularly apposite as some suggest that patients involved in codesigning services can be considered as 'part-time employees' of the organization (McCull-Kennedy et al., 2012). Third, we note potential to consider (3) 'How can organizations support patients' who elect not to participate in service delivery and improvement, or whose preferences change over time?' If healthcare is truly patient-centred, how do we avoid the equivalent of participatory 'junk mail'? And how can we support transitions in preferred levels of involvement over time, for the same patient (c.f. Thompson, 2007). Fourth, given the relational interdependence between patients' and professionals' roles in service delivery and improvement, we emphasise a need to develop understanding of 'What are the implications of enabling patient involvement for health care professionals' roles?' Last, in closing we reiterate potential for theoretical lenses from services marketing and human resource management, as well as organisation studies more broadly, to help us better conceptualise the role of patients in healthcare organisations, and the individual, employee, organisational and contextual factors that may help and hinder their involvement in service delivery and improvement.

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